PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION ____

MR. SPEAKER:

I move that Engrossed Senate Bill 462 be amended to read as follows:

Page 14, after line 42, begin a new paragraph and insert:

"SECTION 7. IC 27-8-10-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 3. (a) An association policy issued under this chapter may pay usual and customary charges or use other reimbursement systems that are consistent with managed care plans, including fixed fee schedules and capitated reimbursement, for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. **However, the amount of reimbursement for a health care service covered under an association policy may not exceed the amount of reimbursement for the same health care service under Medicare.**

(b) Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health

professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic X-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

~~(b)~~ **(c)** A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

~~(c)~~ **(d)** This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

~~(d)~~ **(e)** For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

~~(e)~~ **(f)** The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

~~(f)~~ **(g)** The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

~~(g)~~ **(h)** This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

~~(h)~~ **(i)** This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may

take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.".

Page 24, after line 29, begin a new paragraph and insert:

"SECTION 17. [EFFECTIVE JULY 1, 2003] **If the amount of reimbursement for health care services covered under an Indiana comprehensive health insurance association policy is specified under a contract with a health care provider, IC 27-8-10-3, as amended by this act, applies to a contract specifying the amount of reimbursement for health care services that is entered into, delivered, amended, or renewed after June 30, 2003.**".

Renumber all SECTIONS consecutively.

(Reference is to ESB 462 as printed March 28, 2003.)

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Representative Ripley